

FILED FEB 23 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

5800

State File No. ....

BIRTH NO. .... REG. DIST. NO. 294 PRIMARY REG. DIST. NO. 3056 Registrar's No. 42

1. PLACE OF DEATH a. COUNTY <u>RANDOLPH</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>HOWARD</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>MOBERLY</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>8 MILES N.W. ARMSTRONG</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>MCCORMICK HOSPITAL</u>		d. STREET ADDRESS (If rural, give location) <u>RURAL</u> <u>0450</u> <u>1</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>ETTA</u> b. (Middle) <u>COLLINS</u> c. (Last) <u>WALKER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>FEB 9 1950</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>SEPT 14, 1874</u>
9. AGE (In years last birthday) <u>75</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>AUBURN CALIFORNIA U.S.A.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>JAMES COLLINS</u>		13b. MOTHER'S MAIDEN NAME <u>MARY E GAINES</u>		14. NAME OF HUSBAND OR WIFE <u>ROBERT J. WALKER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Marion Walker Armstrong</u> ADDRESS <u>4222</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Senility &amp; cardiac arrhythmia</u>  ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>myocarditis</u> DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.  INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u>	
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19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	

22. I hereby certify that I attended the deceased from 2 - 9, 1948, to 2 - 9, 1950, that I last saw the deceased alive on 2 - 9, 1950, and that death occurred at 10:32 P. M., from the causes and on the date stated above.

23a. SIGNATURE <u>A. J. McCormick, M.D.</u> (Degree or title)		23b. ADDRESS <u>Moberly Mo</u>		23c. DATE SIGNED <u>2-14-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>FEB 12 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>ROANOKE</u>	
24d. LOCATION (City, town, or county) (State) <u>ROANOKE MO.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Greenough</u> ADDRESS <u>Glasgow</u>			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED FEB 20 19  
District Health Officer N  
District File No. 230  
Feb 6-1900  
Date Filed \_\_\_\_\_

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

\_\_\_\_\_, Student Embalmer No. \_\_\_\_\_,  
working under my personal supervision.

Signed.....  
Student Embalmer

Signed

*J. Walker Audsley*  
Licensed Embalmer No. 3336

P. O. Address

*Glasgow Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.